Fertility Wellness Institute
NeeOo W. Chin MD

PATIENT REGISTRATION FORM

Date:_____ Referred By (name and phone):_____

FEMALE PATIENT INFORMATION

Name:_____ Date of Birth:_____

SS#:_____ Address:_____ City:_____

State:____ Zip Code:_____ Home Phone:( )_____ Work Phone:( )_____

Cell Phone:( )_____ Sex:_____ Marital Status:_____ Race:_____

Employer Name:_____ Employer Address:_____

Occupation:_____ Business Phone:( )_____ ext:_____

Emergency Contact: _____ Phone:( )_____ Relation:_____

HUSBAND/PARTNER INFORMATION

Name:_____ Date of Birth:_____

SS#:_____ Address:_____ City:_____

State:____ Zip Code:_____ Home Phone:( )_____ Work Phone:( )_____

Cell Phone:( )_____ Sex:_____ Marital Status:_____ Race:_____

Employer Name:_____ Employer Address:_____

Occupation:_____ Business Phone:( )_____ ext:_____

Emergency Contact: _____ Phone:( )_____ Relation:_____

PT / Partner

_____ _____ (initial) I hereby authorize NeeOo W. Chin, MD to release information to insurance carriers regarding my diagnosis and treatment and assign to this physician all reimbursement for medical services rendered.

_____ _____ (initial) I acknowledge that NeeOo W. Chin, MD is not a participating physician provider for Medicare or Medicaid. If any service provided to me by Dr. Chin would be deemed eligible for coverage under Medicare or Medicaid if provided by a participating provider, I hereby affirm that I waive any benefits that would be due me under Medicare or Medicaid. I also affirm that I will not attempt to submit any claim to Medicare or Medicaid for any service provided by Dr. Chin.

I FURTHER UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES NOT COVERED BY INSURANCE.

Patient Signature: _____ Date:_____

Partner Signature: _____ Date:_____

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